Nursing VOICE

Volume 1, Number 2 • August 1989

ETHICS – Understanding Makes Advocates Not Adversaries

Leah Curtin, editor *Nursing Management,* is a contemporary author and lecturer in a growing specialty – nursing ethics. She identifies a new sense of responsibility in ethical decision making. In this recent interview, Ms. Curtin shares her thoughts with *Nursing Voice.*

"The staff nurse spends more time with the patient than any other health care professional. He/she observes human suffering, listens to problems and answers questions of patients and families. The nurse serves as an interpreter at the bedside to help patients and families articulate their questions. He/she coaches the patient to ask questions of the physicians. If there is irresolvable conflict of values, the nurse can bring it to the attention of the ethics committee," Curtin observes.

She continues, "I think the most crucial ethical component is helping patients and families articulate their values. The more nurses teach patients how to ask the questions, what questions to ask and how to work the system, the stronger and more independent they become.

"Paternalism in medicine is the physician making the value decisions for the patient. In nursing, we use maternalism, which means we often act for the patient when the patient can act for himself. Both approaches are negative.

"At times, being a patient advocate places nurses in conflict with other health care-givers. Ms. Curtin says that "we are all patient advocates – physicians, nurses, physical therapists, pharmacists, etc. One problem is this advocacy may be interpreted in a legalistic sense. That is, the attorney is advocate for the client and he is out there doing battle against the enemy.

Leah Curtin

"Sometimes patient advocacy is interpreted as setting up adversarial relationships. In the vast majority of instances, this is not so. When there is genuine conflict of opinion about what is in a patient's best interest, it is best resolved by neutral parties such as an ethics committee. This facilitates communications among all patient advocates.

"Everyone needs to know the system and the proper communication channels. Until nurses understand this, they will have a very difficult time feeling comfortable as advocates. Then, they are likely to revert to 'you and me against the world' posture – just me and the patient against the world which is out to get us. This attitude fares poorly in a collaborative effort."

Nurses often feel physicians have extreme difficulty in saying "we can do no more." Whereas, nurses are the first to question unending aggressive therapy, causing the patient continued suffering. "One thing that has helped nurses to understand the physicians' responsibility is role playing," states Ms. Curtin. "You actually have the nurse play the part of being the one to tell the patient 'You are going to die.' The nurse then understands how and why physicians want to say 'well we could try this' and watch desperate faces turn to hope.

"Doctors want to ease the despair just as much as nurses do. Prolonging the end is not right ethically, but understandable. We must learn from our experiences. Once there is understanding of what it means to have been there, we can help each other to cope with, and benefit from, the dilemma of ethical problems."

Louise Oswald, R.N., GICU-E
Jane Borbe, R.N., PCCU

The Allentown Hospital – Lehigh Valley Hospital Center
A HealthEast Hospital

Speaking Out

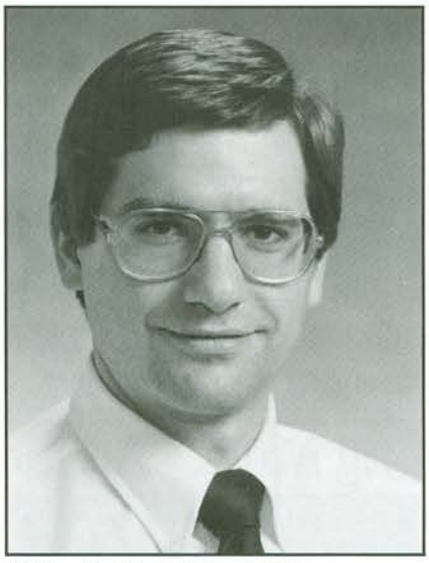
'Doctor, Do Everything'

A 68-year-old retired trucker was admitted with a chief complaint of weight loss, anorexia, fatigue and back pain. Testing and tissue biopsy were consistent with widely metastatic adenocarcinoma of the lung with cancer involving bone and liver extensively.

The hospital course was marked by the patient's rapid deterioration. He was given daily injections of morphine to control severe bone pain and subsequently developed respiratory and hepatic insufficiency. While the attending and consultant physicians recommended no further aggressive medical intervention, the patient's wife and family insisted that doctors "do everything" to prolong life. Nursing was uncomfortable with giving morphine in high doses and the resident staff were concerned the patient was not made a DNR. The attending physician felt he was hopelessly ill and that all further medical care was futile, but at the same time wrote orders for continued aggressive care because he felt it was ethically and legally mandated.

The ethical questions that arose in this case were not unique. Do patients and their families have ethical rights or legal rights to demand tests or medical care which in the attending physician's judgment is futile? Are there ethical limits to the interventions that hopelessly ill patients should receive? Should morphine continue to be given at the expense of respiratory embarrassment?

While there are no cut and dry answers by which to judge all cases, here are a few guidelines which provide an ethical approach to the case.



John E. Castaldo, M.D.

1. First and foremost, physicians and nurses need to help patients and their families define what is meant by "doctor, do everything". For patients it often means something different than to doctors. For patients, it most often means do everything possible within reason which might make me better.

For physicians it is often taken to mean, do everything possible to learn all you can about my illness and prolong my life as long as is medically possible at all costs. This misunderstanding of communication usually is solved by frank discussion with patients and families about the hopelessness of a disease and the futility of treatment. This knowledge, shared compassionately, often solves many hidden problems in deciding patient care at a later date. While patients have the ethical right to limit medical intervention on their behalf, they do not have the ethical or legal mandate to demand tests or procedures which are not medically warranted and of no objective benefit to the patient's welfare.

2. Even after the futility of treatment is explained, physicians and nurses should understand the order "doctor, do everything" may be a temporizing response to an emotional crisis. Families and patients are grieving and this may be a part of their denial of the futility of treatment. Rather than face the grim prognosis immediately, they demand a flurry of tests "second opinions" as if to "buy time" for them to accept that no treatment is possible and death is truly near. For some families, "do everything" may be a hateful response to the guilt of neglecting a loved one earlier in the course of his illness.

3. Physicians need to speak openly and honestly with family members and set goals and limits to the level of care for hopelessly ill patients. In the above case, where death from a widely disseminated disease was imminent, the focus of care should be aimed at patient comfort, not the prolongation of the dying process. In evaluating the burdens and benefits of treatment with a patient or family, often it is reasonable to decide to eliminate antibiotics and nutritional support as well as withholding aggressive technological interventions. Patient comfort and palliation of pain should be maintained at all costs even if it means hastening death.

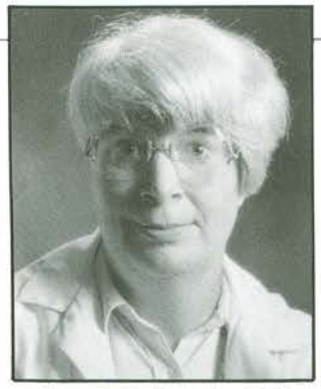
4. Finally, physicians and nurses need to recognize the importance of flexible care for the dying patient. Physicians, when possible, should initiate timely discussions with patient and family regarding life-sustaining treatment in terminal care. Difficult as these discussions are, they allow patients to achieve greater autonomy over their disease, to understand the burdens and benefits of various treatment and different stages of their illness, and to emotionally adjust to the process with greater trust and appreciation for the level of care given.

John E. Castaldo

John E. Castaldo, M.D. is chairman of the TAH–LVHC Medical Ethics Committee. The committee was recognized as an official committee of the executive Medical Staff in 1986 and serves to assist the Medical Staff at both sites in medical-ethical decision making.

Speaking Out

'Take A Stand, To Stand Alone'



Carole J. Moretz, R.N.

Susan Busits O'Neill, R.N.

The only nurses we see being effective in ethical situations are in educational documentaries.

Nurses are reluctant to tackle ethical problems. We are confident to recommend a chest X-ray and arterial blood gas for a patient when decreased right field breath sounds develop. When the same patient equivocates over treatment decisions, we hesitate to arrange a conference with the physician and family. Why?

When confronted with an ethical problem, we first talk with each other. Days full of numerous discussions ensue. We gather many opinions and confuse the issue. We lose valuable time. When we finally approach the physician or family, we are afraid we will stand alone. We find those who spoke out in the morning report are not there to support us. We are left standing alone, feeling at risk.

Sometimes there is just not enough energy to meet all the patients' needs. The ride home after an emotionally packed day is endless. Our minds race and search for resolutions. Did we forget to call lab results or to give a treatment? Patients ' unresolved ethical concerns add tension to the rumination. These issues are soon lost among competing priorities.

Then there is the fear of repercussion. Persons in powerful roles may disagree with either the nurse or patient. No one wants to be "wrong". Worse still is being caught in a "no-win" situation. A common example is the decision to move a patient from critical care to a medical-surgical environment. While many hours of care are necessary for the patient, the unavoidable over-stimulation and lack of privacy in an ICU are deleterious. The medical-surgical unit, however, may provide for privacy needs, but have difficulty providing sufficient care hours. In either case, the patient both gains and loses. If the nurse's position concerning the move does not happen to be congruent with the physician's or utilization review committee's, he/she may be shouted at, "talked down to", or in other ways made to feel inferior. The incident may color the nurse's relationship with the other professionals into the future.

As we each grow both professionally and personally, we can develop the skills to 'take a stand' and to 'stand alone.'

Lastly, there is a dearth of good models and collegial expectations. The only nurses we see being effective in ethical situations are in educational documentaries. If we "miss" a 1300 IV antibiotic, our peers will remind us. If we "miss" an ethical issue, we are unlikely to be reminded. The invisibility of ethically effective nurses and silence create a prohibitive milieu. What should be the norm becomes the exception.

It doesn't have to be this way. Bioethical issues should be unavoidable for nurses. Those who play an instrumental role in initiating resolutions of ethical problems will agree, it is a special and rewarding experience. It creates and restores a sense of peace and justice. It serves the patient in defining "best interest". It addresses unresolved fears within ourselves. As we each grow both professionally and personally, we can develop the skills to "take a stand" and to "stand alone". Only then can we really accept the challenge of ethical health care.

Carole J. Moretz

Susan Busits O'Neill

Carole Moretz, R.N.
Susan Busits O'Neill, R.N.
Co-Editors, Nursing Voice

Nurses Grapple For Solut

Webster defines ethics as "a discipline dealing with what is good and bad and with moral duty and obligation", "a set of moral principles or values," or "the principles of conduct governing an individual or group."

Just as members of a profession are guided by ethics, so too are different populations of people. In health care, the patient should be respected as an individual with fundamental human rights. Inherent in the definition of patient is a list of rights and responsibilities. This "Bill of Rights" assures the patient that his best interests will be served while he is in the hospital environment. In turn, his responsibility to the hospital is to provide information and cooperation in attaining an optimal condition of health.

Frequently, nurses face ethically unacceptable situations over which they have little or no direct control. Many questions arise. Registered Nurses at both sites of TAH–LVHC were interviewed to determine the ethical issues currently affecting their practice. Two staff nurses from the main operating room at the Hospital Center identified the very dramatic impact of caring for trauma victims. Code Red patients are protected by the Patients' Bill of Rights, but where does medical care stop and heroism begin? Is there a point when treatment is for those rendering therapy and the patient no longer benefits? Are supplies, equipment and blood products needed for another patient who is now detrimentally affected? Will the patient die no matter what the therapy? Is this a ritual vs. optimal care?

Nurses in the Shock Trauma Unit voice similar concerns. Are the family and patient consistently informed of the patient's status? Have they been made aware of the probable outcome of therapy and were options presented? Is it their wish to continue with therapy? Is communication practiced with them, vs. at them? Frustration occurs when there is the means to provide treatment, but the outcome is questioned. Should we continue a futile effort and to what end?

On 5A, two staff nurses raised questions concerning patients with a diagnosis of substance abuse and suicidal tendencies. When these clients return to their former lifestyle, they are likely to repeat noncompliant behavior. Can we reform them? Should we? Professionally, the nurse must deal with each person on an individual basis. Dealing with the person and not the action helps these staff members maintain a better perspective.

Staff nurses from 4T and 5T at TAH site identified death and dying issues as the major ethical dilemma they face. Continuing therapy for pain relief when a patient's condition is deteriorating, presents the question of therapeutic value vs. the issue of euthanasia. Should tube feedings be limited? Is the time invested with this patient's care keeping staff occupied when other patients needs are minimally met?

The challenges of universal precautions and the risks involved in care of patients with Acquired Immune Deficiency Syndrome and other communicable diseases are major issues confronting nursing. The ER staff at LVHC site feel fair and consistent therapy should be offered to all patients. Communication with family members allows hospital personnel to become aware

Tina Abraham, R.N. (STU) is shown with life support equipment which frequently becomes a part of ethical dilemmas.

ions To Ethical Dilemma

Michael Goldner, M.D. and Tammy Dietrich, R.N. (right) discuss continued advanced life support for a patient in ICU.

of the family's concerns on issues such as, "do not resuscitate."

Answers to these questions are complex and varied. Nurses find they need to support each other in evaluating the critical concept of human rights. There is a dramatic difference in staff morale when an ethical problem is resolved vs. being ignored. Group discussion through patient care conference provides a better understanding of the issues. Nurses agree the focus should be on education and communication. Patients should be provided with the right to self determination and autonomy. Nurses may begin by talking with other nurses. By establishing a basic understanding of ethics in general, the ethical dilemma can become a delineation of beliefs.

Joanne Porter, R.N., CNOR

Thank you for sharing your experiences:
Brian Stahl, R.N., 5A, LVHC site
Beverly Snyder, R.N., ER, LVHC site
Tammy Eisenhart, R.N., OR, LVHC site
Dee Duffy, R.N., OR, LVHC site
Donna Kunsman, R.N., 5A, LVHC site
Paula Thibault, R.N., 5T, TAH site
Sally Dreher, R.N., 4T, TAH site
Marilyn Rourke, R.N., STU, LVHC site

How To Access Ethics Committee

1. Staff nurse to approach nurse manager – Together they review case and problem.
2. Approach attending physician with problem. For further advice:
3. Consult Ethics Committee via chairperson by calling Critical Care Office – ext. 8450. (Does not go in computer)

Recommendations are communicated to persons requesting consult and followed up with a letter.

Guidelines are found in Medical Staff bylaws of Medical Staff committee.

'Right' Or 'Wrong.' Who Decides?

Janine Fiesta, Esq. R.N.

From the ethical standpoint, nurses want to know what they ought to do; not solely what they must do.

As the health care delivery system increases in complexity, the role of the professional nurse has become increasingly difficult. An obvious sequel of this phenomenon is the current nursing shortage. While many factors have contributed to the nursing shortage, nurses have identified actual working conditions as a significant issue. This issue is related to working weekends and different shifts and to problems with relationships with other health care providers in the clinical units.

The very nature of health care delivery mandates a team approach to patient care. A high level of cooperation among physicians, nurses and other health care providers, both professionals and non-professionals, is necessary. Each group of individuals providing care brings with them a sense of values and ethical standards. As individuals, the formation of these values has been influenced by the individual's educational background, as well as her/his own personal background. The result is a dynamic tension influencing the evaluation of any ethical dilemma.

Nurses, as a professional group, have had a long history of high ethical standards. From the legal standpoint, nurses are concerned about what they need to do to protect themselves in a litigation situation. From the ethical standpoint, nurses want to know what they "ought" to do; not solely what they "must" do. The legal standard may be only a minimal standard; what a reasonable professional would do in a particular set of circumstances, it is not the highest standard of care. The ethical standard is not based upon the reasonable person, but rather upon individual values as developed both personally and professionally.

There are many different scenarios, experienced by nurses in daily clinical practice, with ethical implications. A common example for nursing is the situation where the nurse administers the wrong medication to the patient, but the patient does not realize this has occurred. Should the nurse disclose this information to the patient? Must the nurse disclose?

From the legal analysis, this evaluation is based on the issue of physical harm or injury. If the patient has been harmed or may be harmed through future effects of the medication, the nurse has a legal duty to disclose. If, however, no physical harm has or will occur, the nurse is not required to disclose.

Applying an ethical analysis to the same circumstances, one might argue that while physical harm has not occurred, there is harm. Placed in the most negative light, a vulnerable patient without adequate knowledge has been the victim of fraud by a health care provider. Most nurses, faced with this quandary, choose to follow a higher-than-legal standard and to disclose the incident to the patient.

Of great concern to nurses are those situations that may move beyond the realm of ethics. Recently, in Philadelphia, a physician was prosecuted for failing to resuscitate a potentially viable fetus following an abortion. The nurses, who followed the physician's order not to resuscitate, could also have been prosecuted as accessories to a crime. Simple agreement between family and physician upon a certain cause of treatment does not make it "right." The decision may not be "right" from the ethical standpoint and, in addition, may transgress into criminal action.

What is "right" in the health care delivery system is not always easy to define. For the individual staff nurse, communicating with the nurse's manager may help to clarify the situation. Each clinical unit should consider the initiation of educational programs, particularly with a case study focus, to allow all staff to begin to communicate various ethical perspectives. Additional assistance, in the institutional setting, may be provided by the Ethics Committee. The American Nurses Association Code of Ethics may also provide some general guidance.

As nurses (and other health care providers) move through their educational programs, a professional standard of ethics is developed. The continuation of this development, upon completion of the formal educational program, is the responsibility of the individual as a professional. With changes in technology and reimbursement, the entire health care delivery system is in a state of flux. Ethical issues have correspondingly also become more complex. While general guidance and assistance may be available to the nurse through many mechanisms, the determination of what is "right" is ultimately an individual decision.

Janine Fiesta, Esq., R.N.
Vice President, Legal Services

Simpler Times, Simpler Issues

"Ethics" is a highly visible topic in the 1980s. Health care's ethical issues share the spotlight. Articles are found not only in professional journals, but also in popular magazines and newspapers. Television documentaries and news programs focus attention on this difficult issue. This subject is so prominent now that it appears omnipresent.

Constant discussion makes ethical issues appear to be a perpetual problem. Is that indeed true, or are they reflective of the current decades? Interviews with several experienced nurses indicate that issues were very different in previous years.

Catherine Falk Zenz graduated from Allentown Hospital School of Nursing in 1938. She remembers that IV therapy was used primarily as a last resort for seriously ill patients. A nurse had to hold the patients arm steady throughout the infusion. Many patients died of pneumonia because of the lack of effective treatments until the "miracle" of sulfur drugs.

The first use of penicillin at The Allentown Hospital is clearly remembered by Madeline Contini Pfeiffer, a student from the Class of 1942. The medication had to be specially transported from Philadelphia. The patient and her family were told this was a very rare new drug. Mrs. Pfeiffer recalls, "Patients were given the best available treatment, but so little was possible that questions of prolonging life did not arise." She also remembers caring for patients after illegal abortions.

Josephine Ritz and Janice Holtzman discussed illegal abortions and the advent of legalized abortions. Euthanasia was "discussed" in relationship to the care of terminally ill patients, but patients were given the best possible care to prolong life.

The impact of abortion and heroic treatment measures has increased with dramatic advances in medical technology and knowledge. Salley Shankweiler Reeser, Class of '54, worked in Obstetrics throughout the 1950s and recalls the minimal treatments available for premature infants. At that time, artificial respirations were done by compressing the baby's legs to his chest. Most times premature babies did not survive. Now, treatment and survival for very premature infants has advanced dramatically.

These nurses also recalled that "Code Blues" with resuscitation were unknown until the late 1950s and early 1960s. Basic life support as currently practiced is a recent advance, as is much of the medication, fluid therapy and surgical techniques now available. These strides in the practice of medicine have produced drastic changes. The question is no longer "can the patient be treated", but "how much treatment is in the patient's best interest."

Changes in cultural values also affect the ethics of practice of health care providers. As recently as 1970, nurses did not tell patients anything, including the names of their medicines. Patients were told they must ask the doctor for information on their diagnosis, treatment and prognosis. Now the role of the nurse as teacher is well established. More patients expect to be informed and many demand increased participation in decision making. As public knowledge and awareness grows, additional pressures are placed on the entire health care system.

The ethical problems facing health care now may be destined to multiply and intensify as did the problems of the past. Increasing medical knowledge and public demands which clash with financial constraints will continue to force attention on ethical issues.

Darla Stephens, R.N.
Home Care

Voicing Our Best

CERTIFICATIONS

Joy DuGan (MRT) – Oncology Certified Nurse
Susan O'Neill, Joseph D'Amico and **Cathy Webber** (STU) CCRN; **Louisa Lentz** and **Sandra Hamm** (PCCU) CCRN
Loretta Farley, Kathy Reif and **Jean Linnander** (Prenatal Educ. Dept.) Certified Childbirth Educator; **Linda Breidigam** (NN) Certified Childbirth Educator; and **Terri Hildebrand** and **Michele Silfies** (NICU) Certified Childbirth Educator

PRESENTATIONS

Mary Jean Osborne (NEPE&R) presentation: "Missile Injuries: Mechanism of Tissue Destruction" and **Pat Vaccaro** (NEPE&R) presentation: "Electrical Injuries" at AACN National Teaching Institute.
Debra Adomshick (SSU) presentation: "Open Heart Surgery" at Critical Care Course
Judy Bailey (ED), **Trish Lombardo** (ED), **Carol Peffer** (ED), **Gloria George** (ED), and **Mary Cramsey** (ED) presentation: "Safety-Prevention-First Aid" at six elementary schools.
Nancy Eckert (RR), **Bonnie Graboski** (RR) and **Judy Rex** (RR) presentation: "Malignant Hyperthermia – Stress Syndrome of Man"
Joanne McLaughlin (Burn Foundation, NEPE&R) and **Patricia Vaccaro** (NEPE&R) presentation: "Childhood Burn Injury" for New Jersey Association of School Nurses
Joanne McLaughlin (Burn Foundation, NEPE&R) presentation: "Fire and Burn Safety Program for Elderly" at American Society on Aging Conference
Karen Schaefer (NEPE&R) and **Kathy Lucke** (NEPE&R) presentation and poster: "Caring: The Work of the Clinical Nurse Specialist" at the Eastern Nursing Research Society Conference.
Mary Ellen Beideman (Infection Control) presentation: "Infectious Disease and the Health Care Worker" at Conference for Pennsylvania Association of Hospital Employee Health Professionals; and "Occupational Risks for Health Care Workers" to University of Pennsylvania Graduate Nursing Students.
Mary Ellen Beideman (Infection Control) and **Andrea Geshan** (Infection Control) presentation: "Universal Precautions and AIDS Update" at Eastern Pennsylvania Funeral Directors Chapter Meeting.
Irene Ehrgott (NEPE&R) presentation: "Incorporating a Patient Care Conference into a Busy Staff Nurse's Schedule" at the 14th Annual Congress of the Oncology Nursing Society.

PROFESSIONAL ACTIVITIES

Maria Farkas (UR) is the president and **Megan Heintzelman** (UR) is the Secretary for the Quality Assurance Professionals of Eastern Pennsylvania.
CLAS Promotions to Senior Staff Nurse (May 1989)
Carol Abrams (ACCU)
Linda Coy (ICU)
Karen Frey (ACCU)
RoseMary Gilbert (ICU)
Nancy Hall (3T)
Pat Klotz (CNS)
Marcia Lund (STU)
Lori Roeder (BC)
Judy Young (Float Pool)
CLAS Promotions to Nurse Clinician (May 1989)
Joan Collette (LVHC-OR)
Mary Ann Yackabonis (SPU)

AWARDS

Karen Schaefer (NEPE&R) awarded Dorothy Rider Pool Critical Care Scholarship to facilitate development of a critical care track for MSN program at Allentown College of St. Francis de Sales.

EDUCATION

Christine Niznik (NEPE&R) – MSN – Clinical Nurse Specialist in Adult Health with concentration in Nutritional Support/GI Nursing-Allentown College of St. Francis de Sales
Cassandra Snyder (Anesthesia) – Master's Degree in Human Resource Management – University of Scranton
Kim Sterk (Helwig Diabetes Center) – Bachelor of Science in Nursing – Cedar Crest College
Gloria Hamm (3-11 Assistant Coordinator) – Bachelor of Science in Nursing – Kutztown University

Nursing Voice is published quarterly by the Department of Nursing, The Allentown Hospital – Lehigh Valley Hospital Center. For additional information call 778-7915.

Mary Anne K. Keyes, R.N.
Senior Vice President, Nursing
Carole Moretz, R.N.
Susan Busits O'Neill, R.N.
Co-Editors
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HealthEast, a not-for-profit regional health care system, is more than 8,000 professionals, employees and volunteers working to provide you with quality, comprehensive health services.